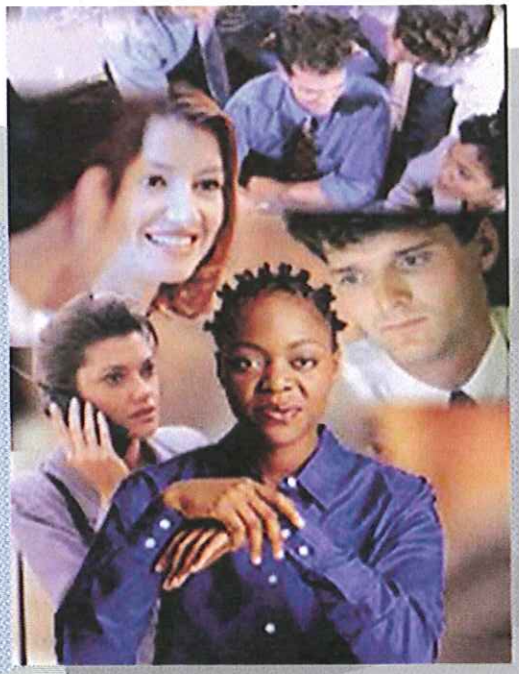
Washington Health Care Authority
Department of Social & Health Services

Washington State
Transitional Bridge Demonstration

Section 1115 Quarterly Report

Demonstration Year 1: 1/1/11 – 12/31/11
Federal Fiscal Quarter 4: 7/1/11 – 9/30/11



2011 - 2013

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

October 13, 2011

Cindy Mann, Director
Center for Medicaid and State Operations
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Dear Ms. Mann:

Since its implementation in January 2011, Washington State's Transitional Bridge 1115 demonstration waiver has been essential to sustain coverage for three populations for whom there were no other affordable coverage options.

Waiver enrollment in these programs was:

- Basic Health – 36,370 (August 2011)
- Medical Care Services (Disability Lifeline) – 16,060 (June 2011)
- Medical Care Services (ADATSA) – 4,192 (June 2011)

This quarterly report documents progress since the conclusion of the 2011 Legislative Session, including further completion of expected milestones as we have begun to prepare for a Special Legislative Session beginning November 28. The state's budget crisis continues as current forecasts show that we will be experiencing a back-to-back biennial reduction in state resources for the first time in over forty years, even after accounting for federal stimulus funds. While the state's population growth and the national economic downturn have increased demands on our health care safety net programs, the state's revenue and ability to meet those demands has stagnated at levels comparable to six years ago.

At the Governor's request, state agencies recently completed exercises to identify cost containment options that would meet a ten-percent cut in agency budgets. The possibility remains that, in order to respond to the current fiscal emergency, Legislative action may include elimination of Transitional Bridge waiver programs, in spite of their value to enrollees and the state. We hope alternate strategies will be developed, but our fiscal status is grim.

We continue our regular interactions with Centers for Medicare and Medicaid Services staff from the Central and Regional Offices and will keep them apprised as details become available that might impact the Transitional Bridge demonstration waiver and other elements of the state's Medicaid program.

Per our current Special Terms and Conditions agreement, Jenny Hamilton, Project Manager, serves as the point of contact for questions on the demonstration. She can be reached at (360) 725-1101 or via email at jenny.hamilton@hca.wa.gov.

Sincerely,

Doug Porter
Director

cc: Preston Cody, Assistant Director, DHS, HCA
Jenny Hamilton, Project Manager, HCP, HCA
Kelly Heilmann, Project Officer
Nancy Klimon, Deputy Director, Division of Integrated Health Systems
Carol Peverly, Associate Regional Administrator DMCHO, CMS

Table of Contents

A. Demonstration Description:

Through the early Medicaid expansion option provided in the Patient Protection and Affordability Act (ACA) Section 1902(k)(2), Washington's Transitional Bridge Demonstration waiver sought approval for Medicaid (Title XIX) matching dollars to help sustain the Basic Health and Medical Care Services (Disability Lifeline and ADATSA) programs until national health reform is fully implemented in 2014. These programs had previously been fully state-funded and as a result of the severe fiscal crisis in Washington state they were eliminated in the Governor's recent proposed supplemental and biennial budgets. The 1115 Demonstration continues to support the following goals:

- Maintain coverage for low-income individuals enrolled in the Basic Health and Medical Care Services (Disability Lifeline and ADATSA) programs until the full expansion of the Medicaid program takes effect in 2014. (*At that time, individuals with family incomes up to 133 percent of the federal poverty level (FPL) will be covered under the Medicaid State plan. Currently these individuals are under age 65, not-pregnant, and not otherwise eligible for Medicaid and Supplement Security Income*.)

- Use the Transitional Bridge programs as a dynamic early-learning laboratory to (a) identify and resolve issues that many states may face in preparing to implement the ACA Medicaid expansion in 2014, and (b) inform federal and state policy makers about program attributes that are consistent with ACA policy goals and provisions and could be considered for new Medicaid expansion and currently Medicaid-eligible populations.

B. State Contacts:

Jenny Hamilton, Project Manager, Health Care Policy
Jenny.Hamilton@hca.wa.gov
(360) 725-1101

Preston Cody, Director, Healthcare Services
Preston.Cody@hca.wa.gov
(360) 412-4361

Managed Care Organization Contract Leads:

Basic Health:

Bob Longhorn,
Robert.Longhorn@hca.wa.gov
(360) 923-2941

Medical Care Services:

Becky McAninch-Dake,
Becky.Mcaninch-Dake@hca.wa.gov
(360) 725-1642

C. Demonstration Progress:

This report provides a comprehensive record of progress on the Transitional Bridge Demonstration for the period July 1, 2011 – September 30, 2011, including the status of milestones, enrollment, the impacts of legislative action, operational challenges and lessons learned, and an overview of budget neutrality. It summarizes regular CMS monitoring calls, with technical assistance requests and implementation issues noted where applicable.

1. Milestone Expectations

The Transitional Bridge Demonstration was approved and became effective January 2011 with an expectation that it would offer a dynamic platform to transition towards national health reform in 2014. Periodic milestones occur over the course of the demonstration and have been included as explicit requirements of the Special Terms and Conditions. Milestones are listed below with a brief description of their current status. Those completed are shaded; those newly completed in this reporting period are shaded in blue.

MILESTONES	STATUS
2011:	
Citizenship determination based on data matching through the social security verification system.	Process was tested and successfully applied to verify citizenship for existing Basic Health enrollees. As previously reported additional data match contract requirements apply to automating the process for new applicants going forward.
Elimination of MCS time limits (i.e., maximum eligibility period of 24 months in a 5 year period).	Completed. Although implemented prior to Transitional Bridge approval, time limits were reversed in response to litigation and to meet CMS' STCs.
Screening of new BH applicants and enrolled BH members (during recertification) for Medicaid eligibility and enrollment.	Implemented. Recertification update provided in Appendix C.
Income determination for identification of BH and MCS individuals eligible for federal match claim based on the Family Medicaid (TANF) methodology as allowed in the CMS guidance letter of April 9, 2010.	Implemented. This is key to determination of Transition Eligible status.
Rollback of monthly premium cost sharing to 2009 levels for the lowest income BH enrollees (i.e., individuals with family income from 0-65 percent of the FPL)	Implemented. Effective 1/1/11 premium contributions for Basic Health enrollees in income band A reduced from $34 to $17 for the duration of the demonstration.
Exemption of American Indian/Alaska Natives from premium and point-of-service cost sharing in Basic Health.	Implemented. Payments made in August retroactive to 1/1/11.
Equitable approach to managing the Basic Health waiting list given priority designation of sponsored AI/ANs and potential impact of eliminating Tribal cost sharing.	
Mental health parity for Basic Health.	Statutory and regulatory changes completed
No cost sharing for preventive care.	Implemented 1/1/11

MILESTONES	STATUS
Elimination of pre-existing condition waiting period for BH children (limited numbers).	Implemented 1/1/11
No reduction in Basic Health benefits; MCS benefits changes tied only to changes in the State Plan.	No change in Basic Health benefits. State Plan amendments (SPA) directed by 2EHB 1087 require MCS benefits revisions to match.
Fair hearings for Basic Health (denials of service) processed through Medicaid systems once the formal Independent Review Organization (IRO) process is exhausted.	Implemented. Washington Administrative Code (WAC) became effective 8/8/11 after final rules filing of 7/8/11. The Basic Health Certificate of coverage was updated and member alert developed to acknowledge new rules. Details available at: www.hca.wa.gov/documents/laws/basichealth/11-01-final.pdf
Systems and processes in place to claim for federal match	Implemented for all 3 demonstration groups.
Administrative and information system challenges and enhancements identified (if any) to: • track out-of-pocket charges and determine 5% aggregate cost sharing cap for low income population coverage options in 2014; • ensure that no federal financing support is claimed for services provided in Institutions for Mental Disease (IMDs) – currently this is approximately 2% of expenditures for the MCS program, 0% for BH; and • allow a smooth interface among coverage options that support low income populations. Manual administrative controls may initially be necessary, with automated processes developed over time to meet PPACA compliance in 2014.	Anticipated as a component of cost-sharing discussions related to the proposal submitted to CMMI by Governor Gregoire (April 29, 2011) for the authority to implement "Health Innovations for Washington". Will be incorporated in end of year processing by the HCA's actuarial consultant. Tested during development of the waiver application. Administrative processes were modified to enhance transitions between Basic Health and Medicaid programs. Discussions with stakeholders resulted in provision of scenarios that will be used to inform transition processing in preparation for the Medicaid expansion in 2014.
2012:	
Competitive purchasing efficiencies including joint BH/Medicaid procurement (with standardized quality and performance measures, application streamlining, common Basic Health/Medicaid managed care delivery system) and delivery system streamlining to fully support mental health parity for all MCS enrollees.	2012 managed care procurement initiated with release of the RFP on 9/13/11. Overview available in Appendix A, a slide presentation to be given to the Health and Human Services Appropriations Committee on 10/11/11.

MILESTONES	STATUS
Methodology implemented for determining and capturing demographic data to identify American Indian/Alaskan Native (AI/AN) tribal membership. This will inform the potential interface requirements among coverage options for low income populations in 2014 to support cost sharing restrictions for AI/AN individuals.	As of 8/30/11, there are 890 Tribal members enrolled in Basic Health through 10 Sponsorship Tribes. Under their agreement with the HCA, Tribal Sponsors are required to obtain and maintain documentation of eligible native status for individuals they sponsor. Exemption from cost-sharing is now in place, made retro-active to 1/1/11 and established in managed care contracts. Additionally the HCA is working through the American Indian Health Commission to develop processes for the identification of other eligible American Indian/Alaska Native populations. *Preliminary* documentation requirements were included in the previous quarterly report and we look forward to CMS guidance.
Elimination of pre-existing condition waiting period for BH adults.	Incorporated in 2012 contract but effectively implemented already given constraints in enrollment.
2013:	
Modified adjusted gross income (MAGI) calculation for Basic Health program eligibility (assuming details known) as an opportunity to work out any administrative challenges prior to PPACA compliance in 2014.	HCA staff is engaged with CMS in ongoing discussions of ACA impact on eligibility. We met with CMS on 9/7/11 in Baltimore and submitted a proposal on 9/16/11 to pilot MAGI in Medicaid/CHIP. We are awaiting further input from CMS.
Cost sharing evaluation findings (and implications) available.	See preliminary Evaluation Plan included in previous quarterly report.
Systems expansion to accommodate federal match and adopt encounter rate payments for services provided in Tribal facilities for AI/ANs covered under capitated contracts.	For further discussion based on implementation of methodology for identifying and tracking AI/AN status. Conversations to raise awareness and understand potential timing of systems changes continue.
2014:	
Prepared to adopt PPACA requirements for Medicaid.	For future discussion.
Single contract (to be considered if state Basic Health option offers best continuity of coverage/cliff avoidance for 133-200% FPL individuals).	

2. Enrollment

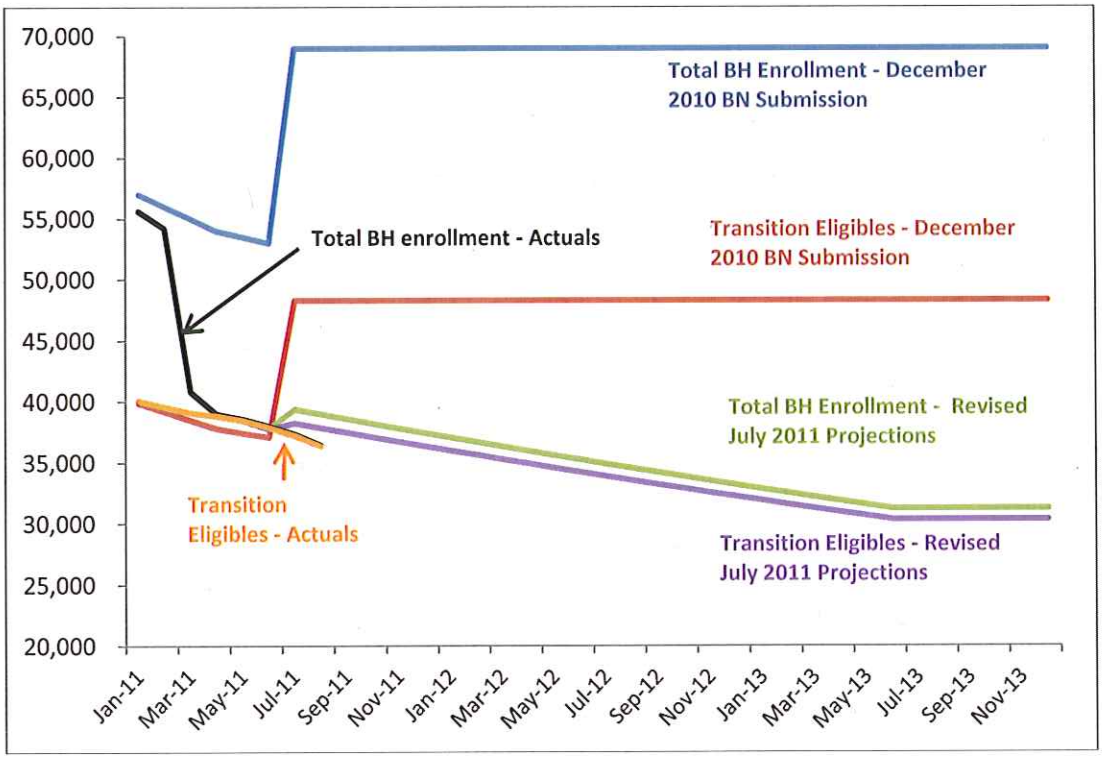
Average (rolling) caseloads and Transition Eligible enrollment in the Basic Health and Medical Care Services (Disability Lifeline and ADATSA) programs are summarized in the following table. Monthly rolling counts for actual and projected enrollment are included with section 4 details on budget neutrality.

Demonstration Group	STC Annual Average Transition Eligibles	Quarterly Rolling Average Program Caseload	Quarterly Rolling Average Transition Eligibles
Basic Health	43,300	Q1 (1/1/11 – 3/31/11) 50,197 Q2 (4/1/11 – 6/30/11) 38,515	Q1 (1/1/11 – 3/31/11) 39,568 Q2 (4/1/11 – 6/30/11) 38,395
Medical Care Services (Disability Lifeline)	16,000	Q1 (1/1/11 – 3/31/11) 17,174 Q2 (4/1/11 – 6/30/11) 16,476	Q1 (1/1/11 – 3/31/11) 16,795 Q2 (4/1/11 – 6/30/11) 16,119
Medical Care Services (ADATSA)	4,000	Q1 (1/1/11 – 3/31/11) 4,187 Q2 (4/1/11 – 6/30/11) 4,188	Q1 (1/1/11 – 3/31/11) 4,183 Q2 (4/1/11 – 6/30/11) 4,181

Demonstration Group Overview:
As a result of continuing deterioration in the state's revenue picture, state agencies were required to develop budgets to meet the Governor's directive to draw up a plan for possible 10 percent cuts. These budgets are currently informing the development of a revised state budget that will be debated during a Special Legislative Session scheduled to begin on November 28, 2011. The Governor's proposed budget is anticipated shortly before the session begins. If the HCA's proposed budget were accepted, the Basic Health, Medical Care Services (Disability Lifeline) and ADATSA programs would all be eliminated on or around January 1, 2012. Further details of the proposed budget package are included as Appendix B. (*This should not be construed as either desirable or final.*)

The following charts portray the current status of enrollment for each demonstration group alongside projections from the original budget neutrality submission and revised projections that followed 2011 Legislative action.

Basic Health Enrollment Projections (1/1/11 – 12/31/13) and Actuals (1/1/11 – 8/31/11)



- **Enrollment by Tribal Sponsorship**
  Since the previous report, 1 Tribal sponsor no longer participates in the Basic Health program because their 2 sponsored enrollees left the program. Otherwise, all Tribal sponsors remain and support a growing proportion of American Indian/Alaska Natives.

Tribal Enrollment in BH: July 2010 – August 2011

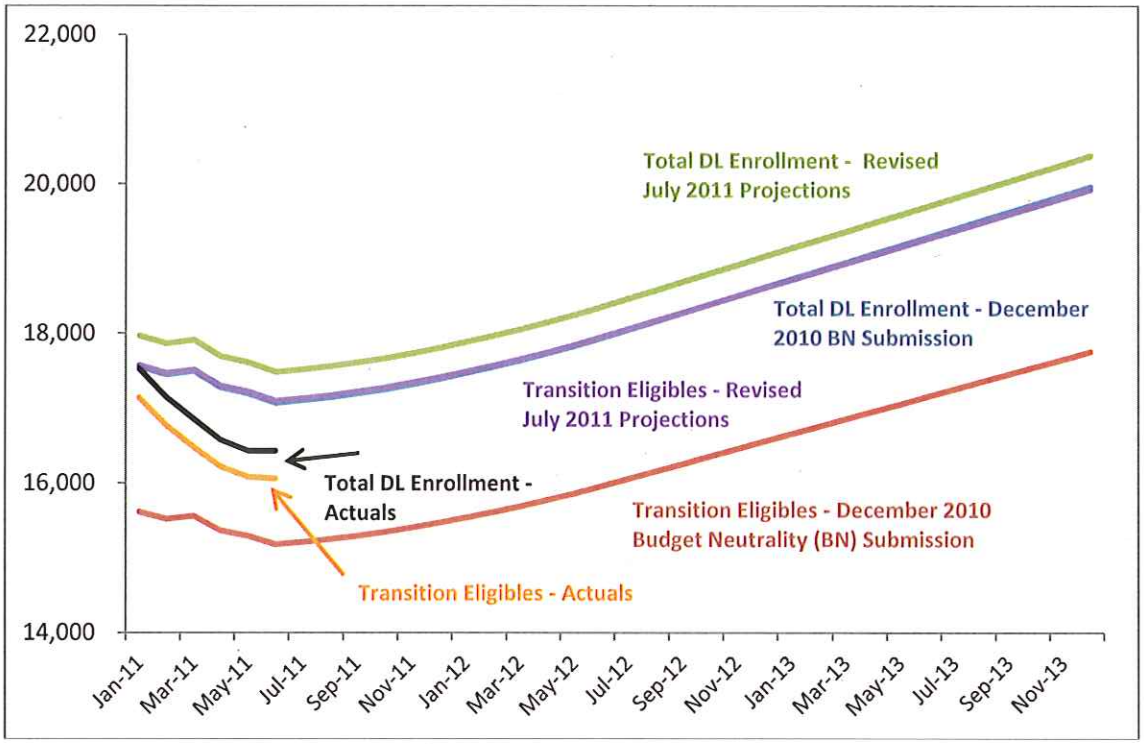
Month of Coverage	Total BH Enrollment	Tribal Enrollment	Percent of Total BH Enrollment
Jul-10	64,105	889	1.4%
Aug-10	62,520	901	1.4%
Sep-10	60,993	880	1.4%
Oct-10	59,542	891	1.5%
Nov-10	57,966	902	1.6%
Dec-10	56,394	911	1.6%
Jan-11	55,614	931	1.7%
Feb-11	54,181	920	1.7%
Mar-11 (TE Pop only)	40,797	906	2.2%
Apr-11	38,824	850	2.2%
May-11	38,475	888	2.3%
Jun-11	37,873	870	2.3%
Jul-11	37,337	878	2.4%
Aug-11	36,454	890	2.4%

- **Distributions of Basic Health by Age and by Income** show no change since previous report

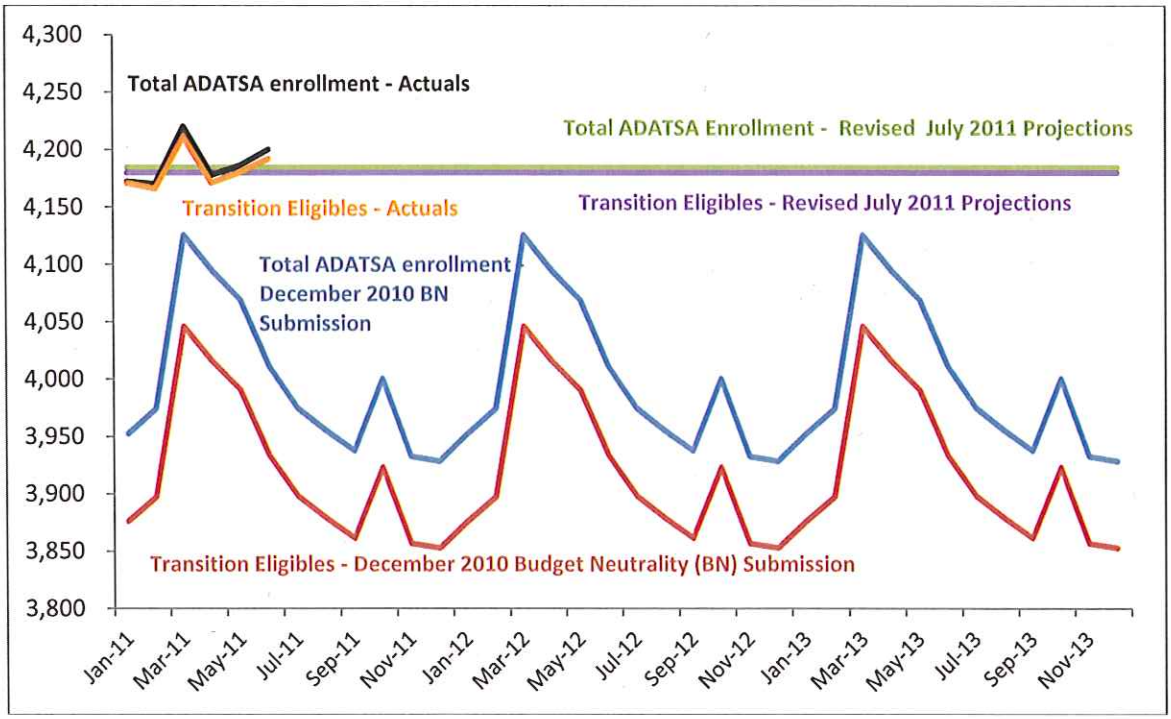
- **Distribution of Basic Health by County and Managed Care Organization (August 2011)**

County	Community Health Plan of Washington	Columbia United Providers	Group Health Cooperative	Molina Healthcare	Total
Adams	232			16	**248**
Asotin	1			59	**60**
Benton	560			60	**620**
Chelan	176			201	**377**
Clallam				787	**787**
Clark	306	2,349			**2,655**
Columbia	3			42	**45**
Cowlitz	555				**555**
Douglas	87			89	**176**
Ferry	78			15	**93**
Franklin	296			38	**334**
Garfield				21	**21**
Grant	299			98	**397**
Grays Harbor	479			212	**691**
Island	389				**389**
Jefferson	397				**397**
King	5,917		3,209		**9,126**
Kitsap	526		484		**1,010**
Kittitas	7			173	**180**
Klickitat	190				**190**
Lewis	292			161	**453**
Lincoln				90	**90**
Mason	294				**294**
Okanogan	142			271	**413**
Pacific	37			129	**166**
Pend Oreille	117			57	**174**
Pierce	751			2,196	**2,947**
San Juan	254				**254**
Skagit	598				**598**
Skamania	72				**72**
Snohomish	1,508		1,248		**2,756**
Spokane	1,043		1,163	1,141	**3,347**
Stevens	461			105	**566**
Thurston	553		706	130	**1,389**
Wahkiakum	56				**56**
Walla Walla	205			170	**375**
Whatcom	418			1,122	**1,540**
Whitman	15			163	**178**
Yakima	1,959			476	**2,435**
Total	**19,273**	**2,349**	**6,810**	**8,022**	**36,454**

MCS – Disability Lifeline Enrollment Projections (1/1/11 – 12/31/13) and Actuals (1/1/11 – 6/31/11)



MCS – ADATSA Enrollment Projections (1/1/11 – 12/31/13) and Actuals (1/1/11 – 6/31/11)



3. Operational Challenges and Lessons Learned

Implementing the Transitional Bridge at the same time as we navigated a difficult Legislative session and continuing economic crisis was a huge operational challenge. Limited resources faced a need to refine complex changes to systems, processes, and managed care contracts, while simultaneously weighing the implications of varying Legislative options for meeting budget constraints and STC requirements. The quick-turnaround timing of business activities to respond to Legislative action[1], the operational uncertainty surrounding the extension of the Legislative session and the budget implications of the continuing decline in revenues, resulted in three major operational challenges.

- A lawsuit was filed in federal district court challenging the disenrollment of Basic Health enrollees who did not meet transition eligibility. While the lawsuit does not affect Transition Eligibles, we are currently engaged in determining the implications of the court ruling on individuals who were previously disenrolled. For reference, the lawsuit is Unthanksikun v. Douglas Porter, et al. No. 2:11-cv-00588, US District Court, Western District of Washington at Seattle.

- Medical Care Services- Disability Lifeline operates under a sole-source contract with CHPW (per STCs), based on the Medicaid Healthy Options contract. A preliminary version of the contract was made available for CMS review; however it made little sense to conduct a full assessment until changes to support Legislative action were clarified. This was a moving target, with final legislation not enacted until 6/15/2011 and not fully effective until 11/1/11. The extent of the changes and the difficulties in establishing revised rates alongside a declining and uncertain fiscal climate delayed the execution of the revised managed care contract. With technical assistance from CMS, a formal request was submitted to extend the deadline until 1/1/12 (see Appendix D.)

- As reported in the previous quarterly report, criteria for coverage through the Medical Care Services programs may no longer result in expenditures that exceed amounts appropriated in the State's operating budget. Appropriations were based on caseload estimates such that there was no immediate need to implement a wait list. However, management of enrollment, given the uncertainty of the state budget, may require imposition of a waiting list in the future, if not the elimination of the program as described in the State Medicaid Director's introductory letter. As a contingency, draft Washington Administrative Code (rules) have been filed to operate a waiting list should one be needed. They are as follows:

  DRAFT WAC 182-508-0150 Enrollment cap for medical care services (MCS)

  1. Enrollment in medical care services (MCS) coverage is subject to available funds.

  2. We may limit enrollment into MCS coverage by implementing an enrollment cap and waiting list.

  3. If you are denied MCS coverage due to an enrollment cap:
     a. You are added to the MCS waiting list based on the date you applied.
     b. Applicants with the oldest application date will be the first to receive an opportunity for enrollment when MCS coverage is available.

[1] HB 1544 was described in section 3 - Legislative Action, in the previous quarterly report, page 11.

4. You are exempted from the enrollment cap and wait list rules when:
    a. MCS was terminated due to agency error; or
    b. You are in the 30-day reconsideration period for incapacity reviews under WAC 388-448-0160(4); or
    c. You are being terminated from a CN medical program and were receiving and eligible for CN coverage prior to the date a wait list was implemented and the following conditions are met:
        i. you met financial and program eligibility criteria for MCS at the time your CN coverage ended; and
        ii. you met the incapacity criteria for MCS at the time your CN coverage ended.
    d. You apply for medical coverage and an eligibility decision is not completed prior to the enrollment cap effective date.

5. If you are sent an offer for MCS enrollment, you must submit a completed application no later than the last day of the month following the month of enrollment offer. You must reapply within this time period and subsequently be determined eligible before MCS coverage can begin. You must reapply and requalify even if you were previously determined eligible for MCS.

6. You are removed from the MCS wait list if you:
    a. are not a Washington resident;
    b. are deceased;
    c. request removal from the wait list;
    d. fail to submit an application after an enrollment offer is sent as described in WAC 182-508-0150(5).
    e. reapply within 30 days of the offer for MCS enrollment, but do not qualify for MCS.
    f. qualify for Categorically or Medically Needy coverage;

STCs require that Transition Eligibles enrolled in the Basic Health program "who have been determined to be American Indians/Alaska Natives" be exempt from cost sharing. The American Indian Health Commission facilitated a work group to support Washington State's efforts to implement this requirement. Appendix A in the previous quarterly report documented the workgroup's progress in:

a. Clarifying the federal definition of an American Indian/Alaska Native (AI/AN), and
b. Determining the array of official documents that would support an individual's claim to be an Indian and therefore exempt from cost sharing.

At this time we have implemented the cost sharing exemption for AI/ANs who are sponsored by a Tribe, since the Tribe is required to maintain official membership records for individuals sponsored. Further implementation and application to preparations for national health reform implementation (e.g., documentation of Indian status for Health Insurance Exchange enrollees) requires CMS guidance on the AI/AN identification methodology.

Lessons Learned

- While the need, design, and implementation of a demonstration waiver in any state are clearly dependent on factors unique to that state, lessons appear to transfer across states. Following the implementation of Washington's Transitional Bridge, many states have contacted us to determine potential application of an 1115 waiver to an early Medicaid expansion in their state. Requests continue following a presentation on the Transitional Bridge at the recent NASHP annual conference http://www.nashpconference.org/agenda/2011-sessions/medicaid-waivers-in-the-era-of-federal-health-reform. Inter-state networking is incredibly valuable.

- Monthly monitoring calls with CMS continue to be helpful as the fiscal context in Washington state potentially puts the future of the Transitional Bridge in jeopardy. Keeping implementation challenges transparent has allowed federal and state partners to collaborate towards the pragmatic resolution of issues.

4. Budget Neutrality

As context for regular budget neutrality progress reporting, the previous quarterly report recapped details of the Transitional Bridge budget neutrality methodology. Appendix E of this report updates the previous budget neutrality tracking report with caseloads, total expenditures and per-caps presented on a "rolling" basis in. Details include:

Original December 2010 STC details (unchanged since previous report):

- Caseloads for the Basic Health (BH), Medical Care Services – Disability Lifeline (MCS-DL) and MCS-ADATSA programs
- Per-capita costs for BH, MCS-DL and MCS-ADATSA programs
- Budget neutrality total expenditures for BH, MCS-DL and MCS-ADATSA programs

July 2011 estimates based on revised caseload forecasts (unchanged since previous report):

- Revised caseloads for the BH, MCS-DL and MCS-ADATSA programs
- Original per-capita costs for MCS-DL and MCS-ADATSA programs
- Revised Basic Health per-capita costs (explanation follows)
- Budget neutrality total expenditures for BH, MCS-DL and MCS-ADATSA programs

Actual caseloads and expenditures (revised and described further below):

- Actual caseloads for the BH, MCS-DL and MCS-ADATSA programs
- Actual per-capita costs for BH, MCS-DL and MCS-ADATSA programs
- Estimated total expenditures for MCS-DL and MCS-ADATSA programs.

Caseload data:

The reporting of actual caseloads differs across the three programs.

- Basic Health operates under full managed care in which enrollees must pay premiums *prior* to the coverage period. As a result, the State is able to provide accurate monthly enrollment one-month after the service month, with minor adjustments for the impact of subsequent transitions to Medicaid and potential retroactive eligibility. This report covers January – August 2011.
- Eligibility status is more complex for the Medical Care Services programs because of systems processing and material retroactive eligibility transfers to Medicaid. As a result, enrollment reflects the fourth month after the service month. This report covers January – June 2011.

Expenditures:

Washington state expenditures are reported and tracked on an accrual (service month) basis; however there are differences across programs as a result of the delivery system complexities.

- Operating under full managed care normally allows Basic Health per-capita data to be reported (and stable) in the third month after the service month. Previous data reported did not include supplemental payment to managed care plans for the AI/AN population exempt from cost

sharing. Current reporting includes adjusted AI/AN payments made following signature of revised managed care contracts. This report covers January – August 2011.

- Medical Care Services benefits are delivered through a combination of managed care and fee-for-service systems. While managed care payments are made prospectively, they are revised for changes in eligibility. Fee-for-service payments are subject to provider billings, in which providers have up to 12-months to bill for services for a given service month. Therefore, actual (stable) per-capita expenditures will begin to be reported six-months after the service month and will continue to be updated for at least 12-months. This report covers January – April 2011 and clearly indicates a lag in data reporting for ADATSA expenditures.

D. Evaluation Plan

A draft evaluation plan outline was submitted in the previous quarterly report to meet STC requirements. Stakeholders have reviewed the plan and submitted a letter with comments and suggestions for modifications. This is included as Appendix F.

Assuming the continuation of the Transitional Bridge waiver in 2012, we look forward to further conversation with CMS to refine the plan and maximize its usefulness for CMS, Washington, and other states during preparation for implementation of national health reform.

Appendices:

Appendix A: Joint Procurement Overview Presentation

Washington State Health Care Authority

Joint Procurement Update

Preston W. Cody, Assistant Director
Divison of Healthcare Services
Washington State Health Care Authority

Joint Procurement purpose and intended outcomes

- Provide the most cost-effective, high-quality health care for enrollees in state-purchased programs.
- Move, where sensible and cost-effective, selected populations currently served in the Fee-For-Service delivery system into managed care.
- Expand managed care capacity and reduce cost trends
- Enhance quality measures tied to performance
- As a result of lowering rates and moving non-dually enrolled Medicaid/Medicare clients into managed care, an overall savings of approximately $73 million are assumed in the 2011-2013 biennial budget.

Joint Procurement populations

Populations included in the RFP?

- Healthy Options clients
- Foster children
- Supplemental Security Income (SSI) recipients
- Disability Lifeline
- Tribes
- Children's Health Program

Input and Stakeholdering

- Posted draft RFP on HCA website to receive stakeholder input
- Meet with potential and current health plans
- Worked with legislative caucuses and Governors policy and legislative staff
- Received input from numerous statewide organizations

Washington State Health Care Authority

Meaningful performance measures

- Limit performance measures to ensure administrative simplification
- Encourage plans to self-monitor
- Focus on specific areas demonstrating quality outcomes

Washington State Health Care Authority

Client auto assignment process

- 50% of clients assigned to carriers entering into new service areas
- Remaining 50% will be distributed to all carriers in that service area based on evaluation score
  - 40% cost
  - 14% for
    a. Access to care and network scores,
    b. Care management, and
    c. Quality assurance and performance improvement
  - 9% for Utilization Management program, Authorization Services, and Grievance

Washington State Health Care Authority

Joint Procurement timeline

Activity	Projected Date*
RFP Release	September 13, 2011
Bidder's Conference	September 29, 2011
Bids Due	December 2, 2011
Bid Evaluations	December 5, 2011 - January 16, 2012
Contracts Awarded	Tentatively February 29, 2012
Readiness Review	March 1 - May 31, 2012
First Coverage Month	July 2012

*Note: Dates subject to change.

Washington State Health Care Authority

Appendix B: HCA Budget Package

STATE OF WASHINGTON

HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

September 22, 2011

TO: Health Care Authority Stakeholders and Providers

FROM: Doug Porter, Director

SUBJECT: HCA's Budget Package

Over the past three years of unrelenting recession, we have diligently scoured our program for efficiencies, savings, and new purchasing strategies that would accomplish good results without sacrificing care. In the merger of the Medicaid program and the Health Care Authority (HCA) on July 1, 2011, we eliminated a set of executive positions that save taxpayers $1 million in state dollars over the coming biennium. Our focus on evidence-based medicine is saving the state more than $30 million a year and our pursuit of Generics First saved more than $100 million in drug expenses last year alone.

With less pride, we have also trimmed back programs, eliminated client services, and reduced customer services – thinning the soup rather than cutting people off coverage – and a conservative estimate is that all those exercises saved the state hundreds of millions of dollars over the past three years. However, the revenue picture continued to deteriorate. Today, we submitted a new budget package to meet the Governor's directive to draw up plans for possible five percent ($223 million) and ten percent ($446 million) cuts in our operating budget. Unlike savings initiatives and purchasing strategies, these are cuts that clearly reduce services and eliminate access to care. They mark degradation in health care for some of the most vulnerable citizens of our state. They also are not good policy, since people who lose access to care often wind up with more serious and more expensive conditions.

On our list is the elimination of the Basic Health plan, which has protected thousands of working poor over more than the past three decades and is considered a national model for covering the working poor. If that cut were accepted by the Legislature, it would also mean the loss of 64 staff positions over the last 18 months of the biennium. Other budget options we have identified include termination of the Disability Lifeline and ADATSA Medical Care Services coverage; the Children's Health Program for immigrant children; the medical interpreter program; all non-emergency dental coverage for adults; funding cuts and payment methodology changes for hospitals, and ending all funding for Maternity Support Services, which offers special support for high-risk pregnant women.

All of these cuts would begin on or around January 1, 2012, (details on these cuts are in a table at the end of this memo).

The most unthinkable cut on the list is our proposal to suspend adult pharmacy services, which means we would not cover the cost of our clients' medicine, in order to reach the ten percent target.

Given the fact that most Medicaid services are mandated by federal law, we must cut state-funded programs not covered by those laws or programs that are considered "optional" under federal Medicaid requirements; however, there are several optional programs that we did not put on our list this year. They include adult hospice, our kidney dialysis coverage, Durable Medical Equipment and the three therapies – physical, occupational, and speech. The direction we received from the Governor and the Legislature last year suggested these were not realistic options to propose this year.

In order to implement these cuts, we would need legislative action this fall for savings to begin in January 2012. Our estimate is that we would need around 60-plus days for legal notices, State Plan Amendments, and official notices to clients and providers. Absent early action, it's likely we would be unable to hit our 10% target.

Whatever legislators decide, it is certain that real people, families, health institutions, and the overall care system in our state will be hurt by some or all of the cuts we are putting into play. Some children who lose coverage will undoubtedly go without care; others will receive inferior care or have to wait until a small illness turns into a major one.

These are grim times, and this is a grim list.

Below is a more detailed look at the programs in the HCA budget package:

Programs listed as options for major cuts	G/F savings possible	Number of clients affected	FTEs affected
Adult pharmacy benefits	$127.5 million	500,000	
Medical for Disability Lifeline and ADATSA	$110.0 million	22,000	
Termination of Basic Health plan	$70.4 million	35,000	64
Termination of Children's Health Program (CHP)	$34.0 million	25,000	
Termination of Maternity Support Services	$21.0 million	54,000	
Hospital Funding: Change payment methodology for Critical Access Hospitals	$19.1 million	--	
All non-emergency adult Dental services	$11.7 million	123,000	
Hospital funding: Reduce CPE hold harmless	$13.9 million	--	
School-based medical services	$5.9 million	22,000	
Interpreter services	$4.8 million	70,000	

Appendix C: Basic Health Enrollment (August)

Total Member Enrollment Summary					
Enrollment Category	**Child Rated**	**Adult Rated**	**Total**	Previous Month Total	Increase (Decrease)
Basic Health Subsidized Enrollment (1)					
Individual Enrollees	1,803	29,695	**31,498**	32,276	(778)
Provider Sponsor	6	136	**142**	145	(3)
Non-Provider Sponsor	154	4,045	**4,199**	4,264	(65)
Employer Group	2	89	**91**	109	(18)
Foster Parents (FP)		521	**521**	540	(19)
Home Care Workers Family	2	1	**3**	3	0
Total BH Subsidized Enrollment	**1,967**	**34,487**	**36,454**	37,337	(883)
Other BH Coverage					
Home Care Workers Subscribers		78	**78**	80	(2)
S-Medical	8	170	**178**	156	22
BH Plus	11,934		**11,934**	11,941	(7)
Health Coverage Tax Credit (HCTC (3))	70	393	**463**	486	(23)
Washington Health	1,080	5,022	**6,102**	5,894	208
Grand Total BHP Enrollment	**15,059**	**40,150**	**55,209**	55,894	(685)

Basic Health Subsidized Modified Adjusted Gross Income up to 133 percent Federal Income Guidelines of Non-Foster Parent members. BH Age Rating and Income Bands reflect BH's premium determination process for all members.

Gross Family Income (% of FPL) Income Band	**Child Rated**	**Adult Rated**					
	A Age 19 - 25	**B Age 19 - 39**	**C Age 40 - 54**	**D Age 55 - 64**	**Total**	**Income Distribution**	Previous Month's
A Up to 65% FPL	482	4,643	4,454	3,441	**13,020**	35.7%	35.8%
B 65% - 99%	514	2,262	3,256	2,098	**8,130**	22.3%	22.2%
C 100% - 124%	349	1,671	2,672	1,500	**6,192**	17.0%	17.1%
D 125% - 139%	202	953	1,258	546	**2,959**	8.1%	8.1%
E 140% - 154%	186	789	1,124	351	**2,450**	6.7%	6.7%
F 155% - 169%	110	634	770	261	**1,775**	4.9%	4.9%
G 170% - 184%	80	403	537	163	**1,183**	3.2%	3.3%
H 185% - 200%	44	199	310	84	**637**	1.7%	1.7%
I 201% -250% (FP)		26	42	19	**87**	0.24%	0.24%
J 251% -300% (FP)		5	10	6	**21**	0.06%	0.04%
Total	**1,967**	**11,585**	**14,433**	**8,469**	**36,454**	**100.0%**	
Age Band Distribution	5.4%	31.8%	39.6%	23.2%	100.0%		
Previous Month's	5.2%	31.9%	39.5%	23.3%			
Female by Age Rating	998	6,907	8,632	5,134	**21,671**		
Male by Age Rating	969	4,678	5,801	3,335	**14,783**		

Basic Health Subsidized Accounts by Ethnicity	
Ethnicity	**Accounts**
Asian Pacific Islander	1,857
Black / African American	163
Hispanic Origin	400

Basic Health Subsidized Accounts by Language	
Language	**Accounts**
Korean	453
Russian	513
Spanish	1,696

Wait List Estimated Individuals (4)	
Capture Date	Count
Jun/30/11	150,682
Aug/1/11	152,595
Change	1.3%

Native American	122	Vietnamese	1,208
White / Caucasian	8,007	Other	5,944
Not Reported	17,726	Not Reported	18,461
Total Enrollment	**28,275**	**Total**	**28,275**

(1) Basic Health Subsidized excludes Home Care Worker Subscribers, S-Medical, BH Plus, HCTC, Washington Health.

Notes: To view additional notes, Unhide below rows.

* "Child Rated" reflects dependents age 19 - 25.

"Adult Rated" reflects ALL subscribers and spouses age 19 and over and disabled dependents over age 25.

(2) Spouses & Dependents of Home Care Workers are counted in the BH Subsidized Category.

(3) HCTC members receiving an advanced credit from the federal program to assist paying monthly premiums.

(4) Estimated number of individuals waiting for coverage based on average members enrolled per account.

Basic Health Recertification Account Details (Calendar Year 2011)

		Jan-11*	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Total
	RECERTIFICATION SENT													
	Assigned ID	0	444	157	233	148	233	213	68					1,496
	Adhoc/Random	0	2,192	1,727	2,550	2,356	2,812	1,044	1,189					13,870
	TOTAL REQUESTS SENT	0	2,636	1,884	2,783	2,504	3,045	1,257	1,257	0	0	0	0	15,366
	RECERTIFICATION COMPLETED													
	Certified (Responded & Subsidy Eligible)	21	1,490	1,381	2,003	1,821								6,716
	Pended - At End of Cycle	0	532	110	173	147								962
1.	Disenrolled - Ineligible for Subsidized BH - (Including Over 200% FIG)	0	40	31	49	36								156
2.	Disenrolled - Voluntarily	2	539	124	97	81								843
3.	Disenrolled - No Response to Recertification - Transferred out of subsidized	2	1	284	477	453								1,217
4.	Total Accounts Disenrolled (1,2,& 3)	4	580	439	623	570	0	0	0	0	0	0	0	2,216
	Total Accounts Completions	25	2,602	1,930	2,799	2,538	0	0	0	0	0	0	0	9,894
	Other Accounts (Removed From Selection)	-25	34	-46	-16	-34	3,045	1,257	1,257	0	0	0	0	5,472
	TOTAL ACCOUNTS	0	2,636	1,884	2,783	2,504	3,045	1,257	1,257	0	0	0	0	15,366
	PERCENTAGE													Average
5.	% Certified	84.0%	57.3%	71.6%	71.6%	71.7%								71.2%
6.	% Pended At The End of Cycle**	0.0%	20.4%	5.7%	6.2%	5.8%								7.6%
7.	% Responded - Not Certified (1,2)	8.0%	22.3%	8.0%	5.2%	4.6%								9.6%
8.	% No Responded, Transferred Out of Subsidized (3 only)	8.0%	0.0%	14.7%	17.0%	17.8%								11.5%
9.	% Accounts Disenrolled	16.0%	22.3%	22.7%	22.3%	22.5%								21.2%
	TOTAL (5,6,7, & 8)	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%

* No accounts were selected for recertification in January 2011 during initial start-up of the Transitional Bridge demonstration.
Each column represents the total number of accounts selected and completed recertification by cycle.
Accounts selected in a month complete the process 90 days later.

**Percent Pended At End of Cycle represents response received and not processed before cycle completion.

Appendix D: Formal Request re Disability Lifeline Contract Submission

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

September 28, 2011

Cindy Mann, Director
Center for Medicaid and State Operations
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Dear Ms. Mann:

As recently discussed with representatives from the Centers for Medicare and Medicaid Services (CMS) in our regular reporting on Washington State's Transitional Bridge Waiver, I am requesting an extension of the deliverable date for the Medical Care Services - Disability Lifeline contract amendments.

Under the original terms of our waiver approval, milestones were established to revise managed care contracts for the Basic Health and Medical Care Services - Disability Lifeline programs to meet CMS approval by April 1, 2011 and July 1, 2011 respectively. To meet the requirements of fiscal and operational constraints imposed by our Legislature during the 2011 Legislative session and allay concerns by our managed care organizations over the surrounding uncertainty, those dates were subsequently extended to October 1, 2011. I am pleased to report that contracts for the Basic Health program, the largest of the three Bridge Waiver populations, have been signed or are being signed this week. With assistance from CMS staff, extensive changes were made to bring the contracts into compliance with CMS requirements.

While we are on target to meet the Basic Health contract milestone, the extent of legislatively directed changes to the Medical Care Services – Disability Lifeline (MCS) program and the difficulties in establishing revised rates amidst a deteriorating fiscal situation have resulted in a complex negotiation climate. Our original intent was to procure MCS coverage through multiple managed care organizations but in the midst of uncertainty regarding the future of the program, our current efforts must focus on sustaining our sole source contract with the Community Health Plan of Washington (CHPW). MCS coverage is not currently an element of our joint procurement efforts for coverage beginning July 2012. Furthermore, given our state's unrelenting recession, a recently announced $1.3 billion deficit, and the Governor's request for a special legislative session beginning November 28, 2011 that potentially includes the elimination of both the BH and MCS programs, we have been unable to execute the revised MCS contract expected by CMS by October 1, 2011. We are requesting an extension of that deadline to January 1, 2012, with a commitment to push for contract execution before that date. Any further delay would be for reasons entirely outside the control of this agency. This extension will also

allow CMS Regional Office staff to finalize the assessment of the MCS contract terms and approve changes made to align with the CMS managed care template.

We are keenly aware that the only reason the BH and MCS programs exist today is because of the partnership reached with the federal government in our Transitional Bridge waiver. In particular we appreciate the continued technical assistance of your staff as we work to sustain the waiver programs.

Per our current Special Terms and Conditions agreement, Jenny Hamilton, Project Manager, will continue to serve as the point of contact for questions on the demonstration. She can be reached at (360) 725-1101 or via email at jenny.hamilton@hca.wa.gov.

Sincerely,

Doug Porter
Director

cc: Preston Cody, Director, Division of Healthcare Services, HCA
Jenny Hamilton, Project Manager, HCA
Kelly Heilmann, Project Officer
Nancy Klimon, Deputy Director, Division of Integrated Health Systems
Carol Peverly, Associate Regional Administrator, DMCHO, CMS

Appendix E: Proposed Budget Neutrality Tracking Worksheets

Worksheets for reporting ongoing budget neutrality tracking follow the proposed approach included in the previous quarterly report, with separate worksheets for each of the demonstration groups. In the "Rolling Actuals" column, data shaded in blue are actual data; data shaded in pink are projections.

Basic Health - Transitional Bridge CY 2011-2013 Budget Neutrality Tracking (Quarterly Report October 11, 2011)

	December 2010 STC Estimates				July 2011 Revised Estimates				Rolling Actuals			
DATE	Total	Waiver Enrollment	Budget Neutrality Per-Capita	Total Budget Neutrality Expenditures	Total	Waiver Enrollment	Budget Neutrality Per-Capita	Total Budget Neutrality Expenditures	Caseload	Waiver Enrollment	Per-Capita	Total Expenditures
Jan-11	57,000	39,900	$184.00	$7,341,600	55,614	40,033	$193.96	$7,764,801	55,614	40,052	$199.62	$7,994,382
Feb-11	56,000	39,200	$184.00	$7,212,800	54,181	39,539	$193.96	$7,668,984	54,181	39,556	$199.20	$7,879,168
Mar-11	55,000	38,500	$184.00	$7,084,000	40,797	39,094	$193.96	$7,582,672	40,797	39,095	$198.90	$7,775,905
Apr-11	54,000	37,800	$184.00	$6,955,200	38,985	38,821	$193.96	$7,529,721	38,985	38,828	$198.43	$7,704,581
May-11	53,500	37,450	$184.00	$6,890,800	38,576	38,454	$193.96	$7,458,538	38,576	38,468	$198.79	$7,646,487
Jun-11	53,000	37,100	$184.00	$6,826,400	37,868	37,782	$193.96	$7,328,197	37,984	37,888	$198.69	$7,527,228
Jul-11	69,000	48,300	$184.00	$8,887,200	39,371	38,247	$201.28	$7,698,292	37,337	37,236	$199.21	$7,476,710
Aug-11	69,000	48,300	$184.00	$8,887,200	38,977	37,864	$201.28	$7,621,309	36,454	36,370	$199.15	$7,477,593
Sep-11	69,000	48,300	$184.00	$8,887,200	38,587	37,486	$201.28	$7,545,096	38,587	37,486	$201.28	$7,545,096
Oct-11	69,000	48,300	$184.00	$8,887,200	38,202	37,111	$201.28	$7,469,645	38,202	37,111	$201.28	$7,469,645
Nov-11	69,000	48,300	$184.00	$8,887,200	37,820	36,740	$201.28	$7,394,948	37,820	36,740	$201.28	$7,394,948
Dec-11	69,000	48,300	$184.00	$8,887,200	37,441	36,372	$201.28	$7,320,999	37,441	36,372	$201.28	$7,320,999
Jan-12	69,000	48,300	$203.44	$9,826,152	37,067	36,008	$212.65	$7,657,205	37,067	36,008	$212.65	$7,657,205
Feb-12	69,000	48,300	$203.44	$9,826,152	36,696	35,648	$212.65	$7,580,633	36,696	35,648	$212.65	$7,580,633
Mar-12	69,000	48,300	$203.44	$9,826,152	36,329	35,292	$212.65	$7,504,827	36,329	35,292	$212.65	$7,504,827
Apr-12	69,000	48,300	$203.44	$9,826,152	35,966	34,939	$212.65	$7,429,779	35,966	34,939	$212.65	$7,429,779
May-12	69,000	48,300	$203.44	$9,826,152	35,606	34,590	$212.65	$7,355,481	35,606	34,590	$212.65	$7,355,481
Jun-12	69,000	48,300	$203.44	$9,826,152	35,250	34,244	$212.65	$7,281,926	35,250	34,244	$212.65	$7,281,926
Jul-12	69,000	48,300	$203.44	$9,826,152	34,898	33,901	$213.32	$7,231,821	34,898	33,901	$213.32	$7,231,821
Aug-12	69,000	48,300	$203.44	$9,826,152	34,549	33,562	$213.32	$7,159,503	34,549	33,562	$213.32	$7,159,503
Sep-12	69,000	48,300	$203.44	$9,826,152	34,203	33,227	$213.32	$7,087,908	34,203	33,227	$213.32	$7,087,908
Oct-12	69,000	48,300	$203.44	$9,826,152	33,861	32,894	$213.32	$7,017,028	33,861	32,894	$213.32	$7,017,028
Nov-12	69,000	48,300	$203.44	$9,826,152	33,523	32,565	$213.32	$6,946,858	33,523	32,565	$213.32	$6,946,858
Dec-12	69,000	48,300	$203.44	$9,826,152	33,187	32,240	$213.32	$6,877,390	33,187	32,240	$213.32	$6,877,390
Jan-13	69,000	48,300	$214.22	$10,346,938	32,856	31,917	$225.35	$7,192,582	32,856	31,917	$225.35	$7,192,582
Feb-13	69,000	48,300	$214.22	$10,346,938	32,527	31,598	$225.35	$7,120,656	32,527	31,598	$225.35	$7,120,656
Mar-13	69,000	48,300	$214.22	$10,346,938	32,202	31,282	$225.35	$7,049,449	32,202	31,282	$225.35	$7,049,449
Apr-13	69,000	48,300	$214.22	$10,346,938	31,880	30,969	$225.35	$6,978,955	31,880	30,969	$225.35	$6,978,955
May-13	69,000	48,300	$214.22	$10,346,938	31,561	30,660	$225.35	$6,909,165	31,561	30,660	$225.35	$6,909,165
Jun-13	69,000	48,300	$214.22	$10,346,938	31,245	30,353	$225.35	$6,840,074	31,245	30,353	$225.35	$6,840,074
Jul-13	69,000	48,300	$214.22	$10,346,938	31,245	30,353	$225.35	$6,840,074	31,245	30,353	$225.35	$6,840,074
Aug-13	69,000	48,300	$214.22	$10,346,938	31,245	30,353	$225.35	$6,840,074	31,245	30,353	$225.35	$6,840,074
Sep-13	69,000	48,300	$214.22	$10,346,938	31,245	30,353	$225.35	$6,840,074	31,245	30,353	$225.35	$6,840,074
Oct-13	69,000	48,300	$214.22	$10,346,938	31,245	30,353	$225.35	$6,840,074	31,245	30,353	$225.35	$6,840,074
Nov-13	69,000	48,300	$214.22	$10,346,938	31,245	30,353	$225.35	$6,840,074	31,245	30,353	$225.35	$6,840,074
Dec-13	69,000	48,300	$214.22	$10,346,938	31,245	30,353	$225.35	$6,840,074	31,245	30,353	$225.35	$6,840,074
CY 2011	61,875	43,313	$184.00	$95,634,000	41,368	38,128	$197.62	$90,383,201	40,998	37,933	$199.76	$91,212,743
CY 2012	69,000	48,300	$203.44	$117,913,824	35,095	34,093	$212.99	$87,130,359	35,095	34,093	$212.99	$87,130,359
CY 2013	69,000	48,300	$214.22	$124,163,257	31,645	30,742	$225.35	$83,131,323	31,645	30,742	$225.35	$83,131,323
Average					36,036	34,321			35,913	34,256		

December Projected Citizenship/Income Transition Eligible Caseload Adjustment	
MCS-DL	88.9%
MCS-ADATSA	98.1%
Basic Health	70.0%

Actual Citizenship/Income Transition Eligible Caseload Adjustment	
MCS-DL	97.8%
MCS-ADATSA	99.9%
Basic Health	72.5%

Actuals
Projections

(Based on enrollment for Jan-Feb, which included sizeable numbers of Transition Eligibles and non-Transition Eligibles.)

Medical Care Services (Disability Lifeline) - Transitional Bridge CY 2011-2013 Budget Neutrality Tracking (Quarterly Report October 11, 2011)

	December 2010 STC Estimates				July 2011 Revised Estimates				Rolling Actuals			
DATE	CFC Nov 2010 Forecasted Caseload	Waiver Enrollment	Budget Neutrality Per-Capita	Total Budget Neutrality Expenditures	CFC Mar 2011 Forecasted Caseload	Waiver Enrollment	Budget Neutrality Per-Capita	Total Budget Neutrality Expenditures	Caseload	Waiver Enrollment	Per-Capita	Total Expenditures
Jan-11	17,553	15,613	$657.57	$10,266,938	17,968	17,572	$657.57	$11,554,632	17,524	17,138	$594.66	$10,191,283
Feb-11	17,448	15,520	$657.57	$10,205,390	17,863	17,469	$657.57	$11,486,964	17,143	16,766	$582.14	$9,760,159
Mar-11	17,494	15,561	$657.57	$10,232,594	17,910	17,514	$657.57	$11,516,873	16,855	16,481	$649.66	$10,707,046
Apr-11	17,275	15,366	$657.57	$10,104,435	17,690	17,300	$657.57	$11,375,973	16,573	16,218	$632.16	$10,252,371
May-11	17,194	15,294	$657.57	$10,057,108	17,610	17,221	$657.57	$11,323,940	16,428	16,080	$657.57	$10,573,718
Jun-11	17,069	15,183	$657.57	$9,983,855	17,484	17,098	$657.57	$11,243,404	16,428	16,060	$657.57	$10,560,567
Jul-11	17,104	15,214	$657.57	$10,004,171	17,519	17,132	$657.57	$11,265,741	17,519	17,132	$657.57	$11,265,741
Aug-11	17,144	15,249	$657.57	$10,027,373	17,559	17,171	$657.57	$11,291,249	17,559	17,171	$657.57	$11,291,249
Sep-11	17,195	15,295	$657.57	$10,057,206	17,610	17,221	$657.57	$11,324,048	17,610	17,221	$657.57	$11,324,048
Oct-11	17,249	15,343	$657.57	$10,089,082	17,664	17,274	$657.57	$11,359,093	17,664	17,274	$657.57	$11,359,093
Nov-11	17,316	15,403	$657.57	$10,128,492	17,732	17,340	$657.57	$11,402,421	17,732	17,340	$657.57	$11,402,421
Dec-11	17,390	15,468	$657.57	$10,171,289	17,805	17,412	$657.57	$11,449,474	17,805	17,412	$657.57	$11,449,474
Jan-12	17,468	15,538	$692.42	$10,758,953	17,884	17,489	$692.42	$12,109,711	17,884	17,489	$692.42	$12,109,711
Feb-12	17,551	15,612	$692.42	$10,809,952	17,966	17,570	$692.42	$12,165,781	17,966	17,570	$692.42	$12,165,781
Mar-12	17,637	15,688	$692.42	$10,862,860	18,052	17,654	$692.42	$12,223,949	18,052	17,654	$692.42	$12,223,949
Apr-12	17,731	15,772	$692.42	$10,920,900	18,147	17,746	$692.42	$12,287,759	18,147	17,746	$692.42	$12,287,759
May-12	17,830	15,860	$692.42	$10,981,879	18,246	17,843	$692.42	$12,354,800	18,246	17,843	$692.42	$12,354,800
Jun-12	17,938	15,956	$692.42	$11,048,139	18,353	17,948	$692.42	$12,427,649	18,353	17,948	$692.42	$12,427,649
Jul-12	18,049	16,054	$692.42	$11,116,309	18,464	18,056	$692.42	$12,502,596	18,464	18,056	$692.42	$12,502,596
Aug-12	18,162	16,155	$692.42	$11,185,782	18,577	18,167	$692.42	$12,578,976	18,577	18,167	$692.42	$12,578,976
Sep-12	18,274	16,255	$692.42	$11,255,201	18,689	18,277	$692.42	$12,655,297	18,689	18,277	$692.42	$12,655,297
Oct-12	18,387	16,355	$692.42	$11,324,584	18,802	18,387	$692.42	$12,731,577	18,802	18,387	$692.42	$12,731,577
Nov-12	18,499	16,455	$692.42	$11,393,913	18,915	18,497	$692.42	$12,807,800	18,915	18,497	$692.42	$12,807,800
Dec-12	18,612	16,555	$692.42	$11,463,231	19,027	18,607	$692.42	$12,884,010	19,027	18,607	$692.42	$12,884,010
Jan-13	18,724	16,655	$729.12	$12,143,751	19,140	18,717	$729.12	$13,647,086	19,140	18,717	$729.12	$13,647,086
Feb-13	18,837	16,755	$729.12	$12,216,721	19,252	18,827	$729.12	$13,727,310	19,252	18,827	$729.12	$13,727,310
Mar-13	18,950	16,856	$729.12	$12,289,692	19,365	18,937	$729.12	$13,807,535	19,365	18,937	$729.12	$13,807,535
Apr-13	19,062	16,956	$729.12	$12,362,672	19,477	19,047	$729.12	$13,887,772	19,477	19,047	$729.12	$13,887,772
May-13	19,175	17,056	$729.12	$12,435,641	19,590	19,157	$729.12	$13,967,995	19,590	19,157	$729.12	$13,967,995
Jun-13	19,287	17,156	$729.12	$12,508,611	19,702	19,267	$729.12	$14,048,220	19,702	19,267	$729.12	$14,048,220
Jul-13	19,399	17,256	$729.12	$12,581,419	19,814	19,377	$729.12	$14,128,267	19,814	19,377	$729.12	$14,128,267
Aug-13	19,513	17,356	$729.12	$12,654,886	19,928	19,488	$729.12	$14,209,038	19,928	19,488	$729.12	$14,209,038
Sep-13	19,625	17,456	$729.12	$12,727,693	20,040	19,598	$729.12	$14,289,083	20,040	19,598	$729.12	$14,289,083
Oct-13	19,737	17,556	$729.12	$12,800,500	20,152	19,708	$729.12	$14,369,129	20,152	19,708	$729.12	$14,369,129
Nov-13	19,849	17,656	$729.12	$12,873,309	20,265	19,817	$729.12	$14,449,177	20,265	19,817	$729.12	$14,449,177
Dec-13	19,963	17,757	$729.12	$12,946,776	20,378	19,928	$729.12	$14,529,948	20,378	19,928	$729.12	$14,529,948
CY 2011	17,286	15,376	$657.57	$121,327,934	17,701	17,310	$657.57	$136,593,812	17,237	16,858	$643.26	$130,137,170
CY 2012	18,012	16,021	$692.42	$133,121,702	18,427	18,020	$692.42	$149,729,905	18,427	18,020	$692.42	$149,729,905
CY 2013	19,343	17,206	$729.12	$150,541,672	19,759	19,322	$729.12	$169,060,560	19,759	19,322	$729.12	$169,060,560
Average					18,629	18,218			18,474	18,067		

December Projected Citizenship/Income Transition Eligible Caseload Adjustment	
MCS-DL	88.9%
MCS-ADATSA	98.1%
Basic Health	70.0%

Actual Citizenship/Income Transition Eligible Caseload Adjustment	
MCS-DL	97.8%
MCS-ADATSA	99.9%
Basic Health	72.5%

(Based on enrollment for Jan-Feb, which included sizeable numbers of Transition Eligibles and non-Transition Eligibles.)

Medical Care Services (ADATSA) - Transitional Bridge CY 2011-2013 Budget Neutrality Tracking (Quarterly Report October 11, 2011)

	December 2010 STC Estimates				July 2011 Revised Estimates				Rolling Actuals			
DATE	CFC Nov 2010 Forecasted Caseload	Waiver Enrollment	Budget Neutrality Per-Capita	Total Budget Neutrality Expenditures	CFC Mar 2011 Forecasted Caseload	Waiver Enrollment	Budget Neutrality Per-Capita	Total Budget Neutrality Expenditures	Caseload	Waiver Enrollment	Per-Capita	Total Expenditures
Jan-11	3,952	3,876	$469.94	$1,821,557	4,184	4,180	$469.94	$1,964,232	4,172	4,171	$ 207.50	$ 865,483
Feb-11	3,974	3,898	$469.94	$1,831,625	4,184	4,180	$469.94	$1,964,232	4,170	4,166	$ 187.76	$ 782,208
Mar-11	4,126	4,046	$469.94	$1,901,342	4,184	4,180	$469.94	$1,964,232	4,220	4,211	$ 208.98	$ 880,015
Apr-11	4,095	4,016	$469.94	$1,887,207	4,184	4,180	$469.94	$1,964,232	4,178	4,171	$ 242.47	$ 1,011,342
May-11	4,069	3,991	$469.94	$1,875,327	4,184	4,180	$469.94	$1,964,232	4,186	4,180	$469.94	$1,964,360
Jun-11	4,011	3,934	$469.94	$1,848,663	4,184	4,180	$469.94	$1,964,232	4,200	4,192	$469.94	$1,969,999
Jul-11	3,975	3,898	$469.94	$1,831,906	4,184	4,180	$469.94	$1,964,232	4,184	4,180	$469.94	$1,964,232
Aug-11	3,955	3,879	$469.94	$1,822,856	4,184	4,180	$469.94	$1,964,232	4,184	4,180	$469.94	$1,964,232
Sep-11	3,937	3,861	$469.94	$1,814,679	4,184	4,180	$469.94	$1,964,232	4,184	4,180	$469.94	$1,964,232
Oct-11	4,000	3,923	$469.94	$1,843,645	4,184	4,180	$469.94	$1,964,232	4,184	4,180	$469.94	$1,964,232
Nov-11	3,933	3,857	$469.94	$1,812,389	4,184	4,180	$469.94	$1,964,232	4,184	4,180	$469.94	$1,964,232
Dec-11	3,928	3,853	$469.94	$1,810,532	4,184	4,180	$469.94	$1,964,232	4,184	4,180	$469.94	$1,964,232
Jan-12	3,952	3,876	$573.27	$2,222,067	4,184	4,180	$573.27	$2,396,112	4,184	4,180	$573.27	$2,396,112
Feb-12	3,974	3,898	$573.27	$2,234,349	4,184	4,180	$573.27	$2,396,112	4,184	4,180	$573.27	$2,396,112
Mar-12	4,126	4,046	$573.27	$2,319,395	4,184	4,180	$573.27	$2,396,112	4,184	4,180	$573.27	$2,396,112
Apr-12	4,095	4,016	$573.27	$2,302,152	4,184	4,180	$573.27	$2,396,112	4,184	4,180	$573.27	$2,396,112
May-12	4,069	3,991	$573.27	$2,287,660	4,184	4,180	$573.27	$2,396,112	4,184	4,180	$573.27	$2,396,112
Jun-12	4,011	3,934	$573.27	$2,255,134	4,184	4,180	$573.27	$2,396,112	4,184	4,180	$573.27	$2,396,112
Jul-12	3,975	3,898	$573.27	$2,234,691	4,184	4,180	$573.27	$2,396,112	4,184	4,180	$573.27	$2,396,112
Aug-12	3,955	3,879	$573.27	$2,223,652	4,184	4,180	$573.27	$2,396,112	4,184	4,180	$573.27	$2,396,112
Sep-12	3,937	3,861	$573.27	$2,213,678	4,184	4,180	$573.27	$2,396,112	4,184	4,180	$573.27	$2,396,112
Oct-12	4,000	3,923	$573.27	$2,249,012	4,184	4,180	$573.27	$2,396,112	4,184	4,180	$573.27	$2,396,112
Nov-12	3,933	3,857	$573.27	$2,210,884	4,184	4,180	$573.27	$2,396,112	4,184	4,180	$573.27	$2,396,112
Dec-12	3,928	3,853	$573.27	$2,208,618	4,184	4,180	$573.27	$2,396,112	4,184	4,180	$573.27	$2,396,112
Jan-13	3,952	3,876	$603.65	$2,339,837	4,184	4,180	$603.65	$2,523,106	4,184	4,180	$603.65	$2,523,106
Feb-13	3,974	3,898	$603.65	$2,352,769	4,184	4,180	$603.65	$2,523,106	4,184	4,180	$603.65	$2,523,106
Mar-13	4,126	4,046	$603.65	$2,442,323	4,184	4,180	$603.65	$2,523,106	4,184	4,180	$603.65	$2,523,106
Apr-13	4,095	4,016	$603.65	$2,424,166	4,184	4,180	$603.65	$2,523,106	4,184	4,180	$603.65	$2,523,106
May-13	4,069	3,991	$603.65	$2,408,906	4,184	4,180	$603.65	$2,523,106	4,184	4,180	$603.65	$2,523,106
Jun-13	4,011	3,934	$603.65	$2,374,656	4,184	4,180	$603.65	$2,523,106	4,184	4,180	$603.65	$2,523,106
Jul-13	3,975	3,898	$603.65	$2,353,130	4,184	4,180	$603.65	$2,523,106	4,184	4,180	$603.65	$2,523,106
Aug-13	3,955	3,879	$603.65	$2,341,506	4,184	4,180	$603.65	$2,523,106	4,184	4,180	$603.65	$2,523,106
Sep-13	3,937	3,861	$603.65	$2,331,003	4,184	4,180	$603.65	$2,523,106	4,184	4,180	$603.65	$2,523,106
Oct-13	4,000	3,923	$603.65	$2,368,210	4,184	4,180	$603.65	$2,523,106	4,184	4,180	$603.65	$2,523,106
Nov-13	3,933	3,857	$603.65	$2,328,060	4,184	4,180	$603.65	$2,523,106	4,184	4,180	$603.65	$2,523,106
Dec-13	3,928	3,853	$603.65	$2,325,675	4,184	4,180	$603.65	$2,523,106	4,184	4,180	$603.65	$2,523,106
CY 2011	3,996	3,919	$469.94	$22,101,728	4,184	4,180	$469.94	$23,570,780	4,186	4,181	$383.85	$19,258,797
CY 2012	3,996	3,919	$573.27	$26,961,292	4,184	4,180	$573.27	$28,753,348	4,184	4,180	$573.27	$28,753,348
CY 2013	3,996	3,919	$603.65	$28,390,240	4,184	4,180	$603.65	$30,277,276	4,184	4,180	$603.65	$30,277,276
Average					4,184	4,180			4,185	4,180		

December Projected Citizenship/Income Transition Eligible Caseload Adjustment	
MCS-DL	88.9%
MCS-ADATSA	98.1%
Basic Health	70.0%

Actual Citizenship/Income Transition Eligible Caseload Adjustment	
MCS-DL	97.8%
MCS-ADATSA	99.9%
Basic Health	72.5%

Actuals
Projections

(Based on enrollment for Jan-Feb, which included sizeable numbers of Transition Eligibles and non-Transition Eligibles.)

Appendix F: Stakeholder Input to Evaluation Plan

THE ALLIANCE
for Equal Justice
MEMBER

NoHLA

Northwest Health Law Advocates

October 7, 2011

Jenny Hamilton
Program Manager
Health Care Authority
Olympia, WA

Sent by email to: jenny.hamilton@dshs.wa.gov

Dear Jenny:

We write to provide input into the Sec. 1115 demonstration evaluation outline proposed by the Health Care Authority (HCA) as described in its July 11 Quarterly Report, which was provided to us on August 30. Our understanding is that this is simply a preliminary outline of ideas for evaluation, rather than a "draft evaluation plan" as required by the waiver, and our comments would be welcome. We appreciate that you are soliciting our input.

As more fully described below, our assessment is that the proposal does not fully comply with the evaluation criteria set forth in the Special Terms and Conditions of the waiver. Those criteria are designed to evaluate whether the experimental design is valid and had value. It is not at all clear that the proposal meets the test. We would be interested in working further with the state and CMS to develop a better evaluation design, and we have included suggestions for doing so.

Special Terms and Conditions Requirements

The waiver requires certain elements in a draft evaluation design, including:

1. Discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target population for the Demonstration.

2. Outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population

3. The data sources and sampling methodology for assessing these outcomes

4. A detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State

4759 15th Ave NE, Suite 305 ♦ Seattle, WA 98105-4404
206-325-6464 ♦ nohla@nohla.org ♦ www.nohla.org

5. Whether the State will conduct the evaluation, or select an outside contractor for the evaluation

6. As a component of the draft evaluation plan for the Demonstration, the State will conduct an outcomes analysis of the impact of CMS approved cost-sharing changes on enrollment and utilization of services.

The State's Draft Evaluation Design Should Be Revised to Meet Waiver Requirements

We address each of the evaluation design elements listed above, noting our concerns that the state's proposed design does not meet the waiver's requirements.

Goals, objectives and hypotheses.

The evaluation should seek to test the goals of the waiver demonstration itself. The state's evaluation outline contains much discussion about goals, but these are not the demonstration waiver goals. The existing waiver was designed to provide the state with a limited Medicaid eligibility expansion in order to transition the Basic Health (and Medical Care Services) programs into Medicaid. However, the state has proposed a different goal for testing through the evaluation: a goal of imposing greater cost-sharing on *existing Medicaid* clients. This is not a part of the existing waiver and therefore not a proper subject of evaluation. The state is attempting to shoehorn an entirely different agenda into the waiver evaluation. Only after this waiver was granted did the state develop ideas about restricting benefits and imposing enforceable cost-sharing on the *existing* Medicaid beneficiaries, reflected in the entirely separate HIW waiver proposal to CMS. We recently heard that CMS has notified Washington that the HIW cost-sharing proposal is not approvable due to limitations on its waiver authority. Using the Transitional Bridge Waiver to test these concepts in a separate proposal – one which is not even approvable - would be entirely inappropriate, like mixing apples and oranges, and would serve no purpose.

Moreover, the draft outline contains no list of specific hypotheses to be tested, as CMS requires. The proposed evaluation components are to "test the impact of BH point-of-service cost-sharing on: (a) utilization of specified services and; (b) health outcomes." There is no indication of what hypotheses will be used in connection with these components, e.g., a hypothesis that cost-sharing deters utilization of unnecessary healthcare services, or creates barriers to enrollees getting necessary healthcare services. It is not clear from the outline how the variables indicated, such as income, eligibility period, age, gender, geographic location, chronic disease prevalence, or "other factors unrelated to utilization" would be evaluated.

It would require some thought to come up with a hypothesis worthy of study that relates to point-of-service cost-sharing. The issue of the impact of cost-sharing on low-income populations is one of the most studied aspects of the Medicaid and CHIP programs. Those studies have uniformly shown that cost-sharing causes Medicaid beneficiaries to go without needed care, and often imposes greater costs than savings to the state and federal governments in the long term. In light of this history, it would be important to include a review of the literature and to demonstrate that this evaluation is not repeating existing studies but is adding something of true value to the knowledge base.

A comprehensive list of cost-sharing studies that should be considered before developing this demonstration evaluation is attached as an Appendix to this letter. However, there might be some value to studying the impact of *eliminating* cost-sharing for American Indians and Alaska Natives, to evaluate whether it led to changes in access to or quality of care, or health status.

Another proposed component of the evaluation is an actuarial comparison of benefit packages (Basic Health, Medicaid, and Essential Health Benefits, which are as yet unknown). It is not clear that this comparison evaluates anything demonstrated by the waiver. We would appreciate clarification on how this comparison would address legitimate goals, objectives or hypotheses related to the waiver. Again, the only goal described for this evaluation is to restrict Categorically Needy Medicaid benefits for the existing non-waiver Medicaid population in ways not currently permitted under Medicaid law. This is unrelated to the Transitional Bridge waiver. Rather, it is an objective pursued in HCA's HIW proposal.

It is not at all clear how the actuarial comparison fits the requirement of a demonstration-related evaluation as it is not testing a hypothesis or performing an experiment or demonstration. It is simply a comparison and at this point in time, there is nothing to compare.

Outcome measures.

Outcome measures are ways of measuring whether a hypothesis is valid. It is hard to determine what the outcome measures would be without a hypothesis. Various measures of service utilization (number of visits, rates of prescriptions, etc.) and adverse events (asthma and diabetes control indicators, mortality, survival) are described, but it is not clear how these measures relate to study outcomes. The proposal refers to "key program outcomes" that are evaluated to "determine the program's effectiveness." We would suggest that one such outcome of the transitional bridge waiver is to maintain enrollees on the program to the extent possible, by reducing the rate of attrition in the Basic Health Program due to reasons such as unaffordability of premiums and cost-sharing. Another outcome is the achievement of improved mental health services through mental health parity, as the waiver has eliminated the caps on inpatient days and outpatient visits. A third outcome is screening BH enrollees for Medicaid eligibility and enrolling those eligible for the more comprehensive program.

Data sources and sampling methodology.

The sources of data are not fully described. We have concerns about the apparent assumption that information drawn from the current Basic Health enrollee population's use of services would be generalizable to the low-income population as a whole. The current BH population represents a very select group of people – those who have survived many changes to the program, including increases in premiums and deductibles, and who have consistently been able to pay their premiums. Basic Health has been in attrition mode for over two years, with many people leaving the program due to inability to pay premiums. Those who remain are therefore not likely to be typical or representative of the group that would ultimately enroll in Medicaid or the Basic Health Option starting in 2014. Thus, a bias would be introduced into the study, unless it specifically controls for or examines this phenomenon. . We would be extremely wary of any finding such as "low-income Basic Health enrollees did not under-utilize services (or had comparable or better health outcomes to Medicaid clients) despite the cost-sharing imposed" because it suggests that one could generalize that the entire low-income population eligible for Medicaid/Basic Health Option in 2014 would not have difficulty meeting cost-sharing obligations. This would be an inappropriate conclusion in light of studies that have

shown that many low-income people cannot afford premiums. These studies are much more predictive of the impact than would be a study of a select group of diminishing size who, by definition, has been able to afford (or have a sponsor pay) monthly premiums for at least 2½ years. In addition, even with a comparison of "propensity score matched" group of people, there would need to be explicit analysis of family budgets (i.e., basic expenses that compete with cost sharing for a given family), and potential outside assistance with medical expenses (e.g., BH financial sponsor, relative, church or clinic), both of which are extremely difficult to obtain. Given the limited predictive value of a study of Basic Health enrollees when applied to Medicaid clients, there is little to be gained from such a study.

The "interrupted time series comparison analysis" would look at individuals who have transitioned from BH to Medicaid to see if their service utilization and health outcomes change as compared to those on BH throughout the entire period. One key factor is missing – the reason for transition to Medicaid. If the person qualified because she met Medicaid disability criteria, that would suggest a decline in the person's condition independent of whether or not their service utilization was appropriate. Even for those who transition based on eligibility for family Medicaid, one would need to be cautious about whether any changes in utilization or health status were unrelated to cost sharing, or even caused by the transition itself.

A client survey seems an appropriate way of finding out how copayments influenced service utilization, from a client perspective. (We would not expect that premiums would influence service utilization.) More information on how this survey would be done, and the questions asked, would be necessary to determine its value. We suggest that the study could survey those who no longer are required to pay co-payments as a result of the waiver – the American Indian/Alaska Native (AI/AN) population. It would also be important to evaluate the impact of premiums on coverage by surveying people who were disenrolled from Basic Health due to non-payment of premiums or other financial reasons.

Detailed analysis plan describing how effects of the demonstration shall be isolated from other state initiatives.

This detail is not discussed in the outline.

Who conducts the evaluation.

This information is not provided.

Analysis of impact of cost-sharing changes on enrollment and utilization of services.

Enrollment: We do not see an indication that the proposed design includes an analysis of the impact of cost-sharing *changes* on enrollment. The only such changes that the Transitional Bridge Waiver made to Basic Health were the elimination of premiums and other cost-sharing for the AI/AN population, and the reduction of premiums for the lowest-income group of enrollees. It would be quite helpful to study the impact of the waiver's reduction of premiums for the individuals under 65% FPL from $34 to $17 per month, and the impact of the elimination of premiums on AI/ANs. This would be of greater benefit than studying the impact of copayments given all the existing studies.

Although not specifically related to cost-sharing, we highly recommend studying the impact of the new "screen and enroll" requirement on the profile of the Basic Health population. Preliminary estimates show that (1) about 25% of Basic Health enrollees are found eligible, (2) the BH population is

aging over time, yet their service utilization is lower than previously, and (3) a large cohort of the BH population has been on the program at least 5 years. Are these factors linked, and if so, how? Is the diversion of enrollees into Medicaid responsible for the decreased service utilization in BH? Is this decreased utilization medically appropriate and if so, is length on the program a contributor to health stability? Or are other factors involved? Profiles of how the two groups use services could be very helpful in getting at these questions. This research, if designed well, could be useful in predicting how the Medicaid expansion population may have a different profile from the original Medicaid population, and how a stable source of coverage could "bend the cost curve."

Utilization: If, as CMS requires, there is a need to study the impact of non-premium cost-sharing on the BH population's utilization of services, we suggest that the state focus on the elimination of AI/AN copayments, and/or the impact of deductibles, since they are less studied than copayments for low-income populations. Perhaps studying the impact of deductibles on Basic Health enrollees' utilization of non-emergent services subject to the deductible could add something of value to the literature; this is worth further consideration and review by CMS. In addition, as suggested above, it would be very interesting to look at the impact of removing the mental health utilization limits (10 inpatient days and 20 outpatient visits) on the lives and health status of those who would otherwise have had no service.

CMS is required to carefully evaluate the research or demonstration value of waivers, as the 9th Circuit recently reaffirmed in a case involving cost-sharing imposed by Arizona's Medicaid program.[1] 42 U.S.C. §1315(a). In that case, the court reaffirmed that the statute "plainly obligates the Secretary to evaluate the merits of a proposed state project, including its scope and potential impact on . . . recipients," and held that the federal agency's administrative record relating to the value of the cost-sharing demonstration was insufficient because it "contains no finding from the Secretary that Arizona's demonstration project will actually demonstrate something different than the last 35-years' worth of health policy research." This decision requires an approach that is relevant to the demonstration, rigorous, and contributes to the body of knowledge.

Conclusion

We appreciate the federal assistance that the Bridge Waiver provides to Washington and hope that a valuable demonstration project can be developed in conjunction with it. We would be glad to meet with you to discuss our concerns and provide input to you in developing a suitable evaluation component.

Thank you for your consideration.

Sincerely,

Janet Varon

Janet Varon
Northwest Health Law Advocates

[1] Newton-Nations v. Betlach, _ F.3d _, 2011 WL 3689241 (9th Cir., August 24, 2011) available at http://www.ca9.uscourts.gov/opinions/view_subpage.php?pk_id=0000011701.

Cc:

Jonathan Seib, Office of the Governor

Douglas Porter, Director, Health Care Authority

Cindy Mann, Center for Medicaid, CHIP and Survey & Certification, Centers for Medicare and Medicaid Services, Department of Health and Human Services